GI ASSOCIATES OF TALLAHASSEE
PLEASE PRINT and complete all fields.

PATIENT INFORMATION

Social Security #_____ Date of Birth_____

Full Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____

Cell Phone #: (_____) _____

Other Phone #: (_____) _____

Email (required): _____

Gender: ❒Male ❒Female Marital Status: ❒Single ❒Married

Race: _____ Ethnicity: _____

EMPLOYMENT INFORMATION

Status: ❒Full Time ❒Part Time ❒Retired ❒Unemployed

Employer: _____

Employer Phone: (_____) _____

PRIMARY INSURANCE (card must be present)

Insurance Name: _____

Insured Name: _____

Insured Date of Birth:_____

Relationship to Patient: _____

Policy #: _____

Group #: _____

Employer: _____

SECONDARY INSURANCE: (card must be present)

Insurance Name: _____

Insured Name: _____

Insured Date of Birth:_____

Relationship to Patient: _____

Policy #: _____

Group #: _____

INFORMATION RELEASE

Emergency Contact Name: _____ Relationship to Patient: _____

Address: _____ Phone #: (_____) _____

Permission to discuss your health information with this person? ❒Yes ❒No

You may also discuss my health information with the following people.

1. _____ 2. _____

YOUR SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING:

1. In understand that I will be charged a $25 fee if I do not cancel my appointment within 48 hours or if I fail to keep the appointment time set aside for me to see the provider.

2. I authorize insurance benefits to be paid directly to GI Associates of Tallahassee. I understand that I am responsible to pay for any amounts not covered by my insurance policies (deductibles, coinsurance, copayments, or other charges incurred). I understand that balances 90 days past due will be sent to a 3rd party collection agency and may be subject to late fees and/or collections proceedings.

3. This document serves as authorization for the release of my medical records to GI Associates of Tallahassee from other physician offices and/or hospitals as necessary for my healthcare and to complete related medical claims, as well as authorization for the release of my medical records from GI Associates of Tallahassee to other physician offices and/or hospitals as necessary for my healthcare and to complete related medical claims.

Signed: _____ Relationship: _____ Date: _____